

FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 48 hours of death.

DMH-M-17 1/71 10M
 (VR A15M (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

76-17807

1. DECEASED NAME (Type or Print)		First <i>Dorothy</i>	Middle <i>E</i>	Last <i>Bradshaw</i>	2a. DATE KNOWN OF DEATH MAILED Month Year	Month Day Year	2b. HOUR 1976 c 8 P.M.
3. SEX Female	4. RACE Cau.	5. DATE OF BIRTH 12-29-23	6. AGE (In years and months) 52 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Caroline	2d. HOUR 1976 10:30 P.M.	
10. CITY OR TOWN OF DEATH Henderson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Henderson	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER None	
14. FATHER'S NAME First ?		Middle Childress	Last ?	15. MOTHER'S MAIDEN NAME First Cleo	Middle	Last ?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 194-32-3917		17. INFORMANT Gayle Moore	ADDRESS Hartly, Del.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) G.S.W. Head DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF lost. (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Louis S. Nefty</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>6-11-76</i>	
EXAMINER'S NAME (Type) Louis S. Nefty		for		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-14-76		23c. NAME OF CEMETERY OR CREMATORIUM Greensboro Cemetery		23d. LOCATION (City or Town) (County) (State) Greensboro Caroline Md	
24. FUNERAL DIRECTOR <i>John E. Boulaire</i>		ADDRESS <i>Greensboro Md 21439</i>		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <i>Patsy McCrady</i>	

entomology

zoology

botany

geology

mineralogy

ethnology

linguistics

philosophy

psychology

mathematics

physics

chemistry

astronomy

metaphysics

epistemology

ontology

logic

metatheory

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

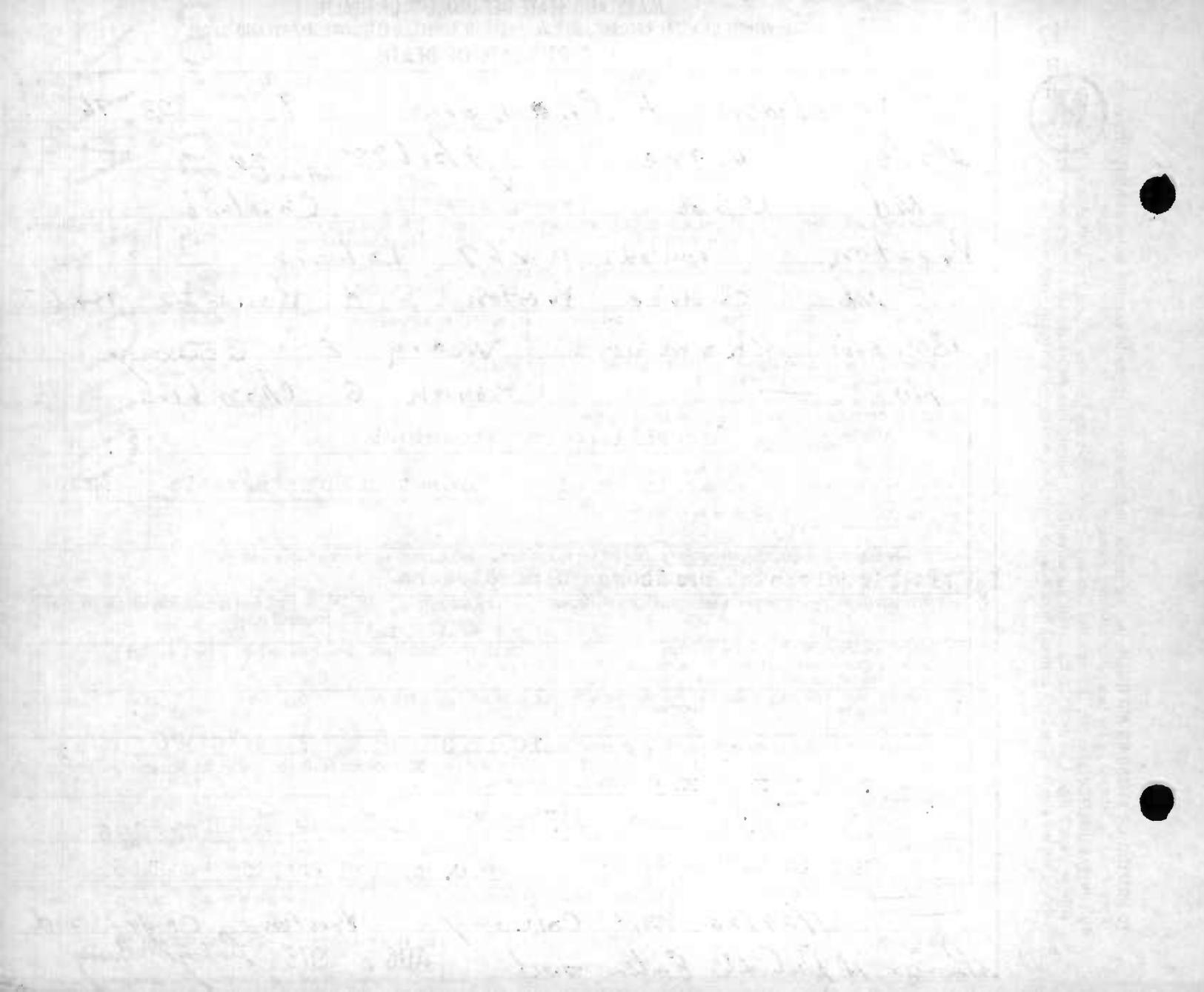
76-17808

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH 7 Month Day 23 Year 76	2b. HOUR M		
3. SEX <i>Male</i>		4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>9/21/98</i>		6. AGE (In years last birthday) <i>77</i> YRS.			
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Caroline</i>		
10. CITY OR TOWN OF DEATH <i>Preston</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rauton & Box 67</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13c. CITY OR TOWN <i>Caroline Preston</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rauton & Box 67</i>		
14. FATHER'S NAME First <i>Bas hui</i>		Middle <i>chambers</i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Mary E</i>		Middle <i>Coursey</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Sarah G. chambers</i>		Address		
18b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized carcinomatosis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>		
18c. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i></i>		18d. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of the prostate with metastasis</i>				5yrs		
		18e. DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic cardiovascular disease</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/1/60</i> , 19 <i>60</i> , to <i>1/23</i> , 19 <i>66</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>10/18/68</i> , 19 <i>68</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (cannot) view the body after death.								
22b. SIGNATURE <i>Harold B. Plummer M.D.</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>7/27/76</i>			
22d. PHYSICIAN'S NAME (Type) <i>Harold B. Plummer M.D.</i>		22e. ADDRESS <i>P.O. Box #129 Preston Md 21655</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>7/29/76</i>		23b. DATE <i>7/29/76</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Calvary</i>		23d. LOCATION (City or Town) <i>Preston</i>	(County) <i>Caroline</i>	(State) <i>Md</i>
24. FUNERAL DIRECTOR <i>George H. DeGraw Eastern</i>		ADDRESS <i></i>		25a. REC'D BY REGISTRAR DATE <i>AUG 5 1976</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>		

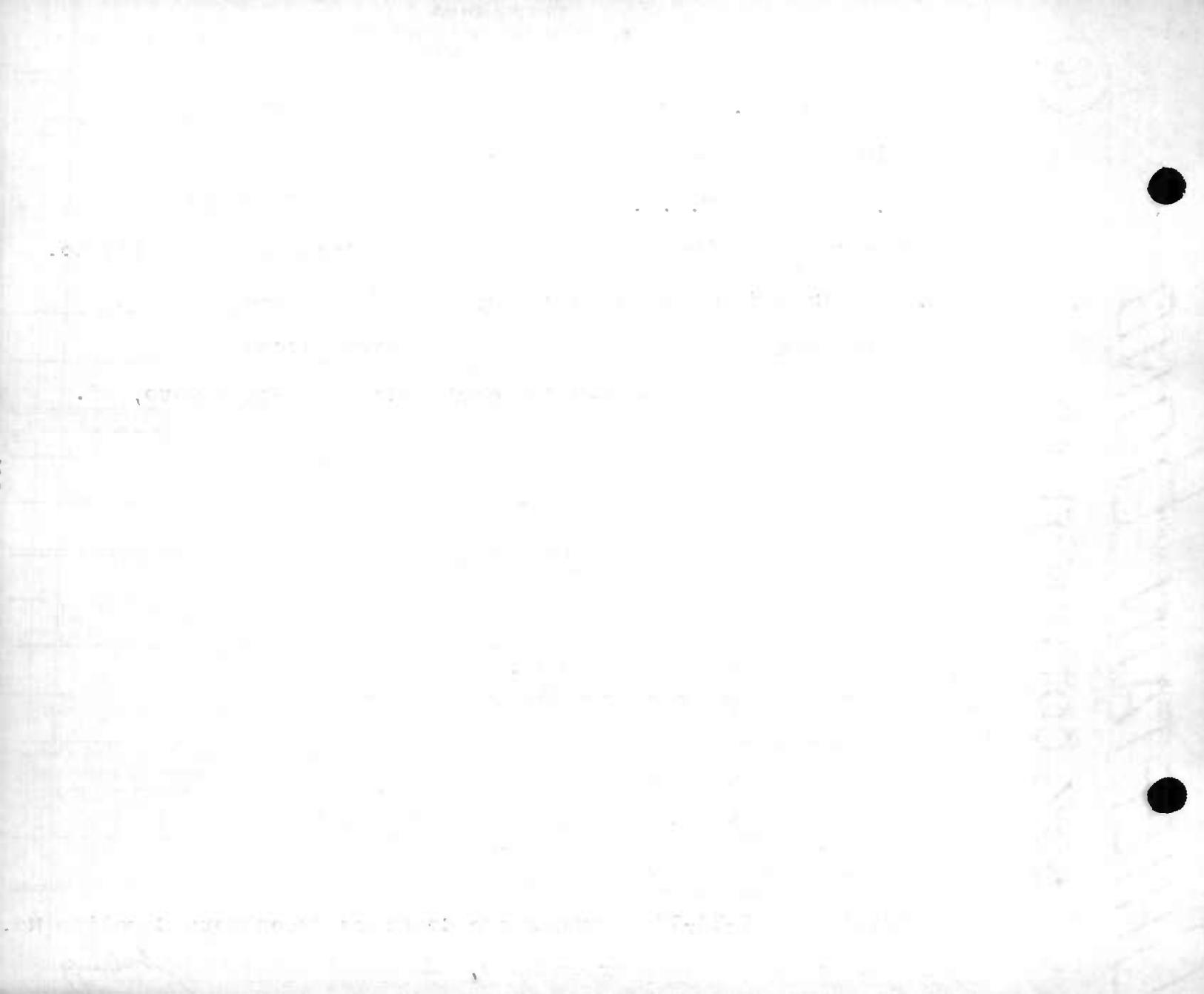


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. <i>76-17809</i>	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR	
<i>John T. Dyer</i>						<i>7-24-76</i>							
3. SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		MONTH <i>2</i> DAY <i>10</i> YEAR <i>1893</i>			83 YRS.			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.								<i>Caroline</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Greensboro		Home			Foreman			Milk Co.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.		Caroline		Greensboro		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			None				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				ADDRESS	
		<i>John</i>	<i>Dyer</i>		<i>Mary Warren</i>			No				<i>Greensboro, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PNEUMONIA</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
<i>2859</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>ANAEDEMIA</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>C.E. Jensen MD</i> DEGREE													
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <i>Denton Md</i>										22f. DATE SIGNED
<i>C.E. JENSEN</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial			<i>7-28-76</i>		Greensboro Cemetery			Greensboro		Caroline		Md.	
24. FUNERAL DIRECTOR NAME <i>John E. Bowles</i>			ADDRESS <i>Greensboro, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>JUL 30 1976</i>			25b. REGISTRAR'S SIGNATURE <i>Patricia McCready</i>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 76-17810		
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-1- 1976			2b. HOUR M 11:45 A.M.		
			Clement Simon Eicks											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7-4- 1976			2d. HOUR M 11:45 A.M.	
Male		Cau.		7-26-05		70								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Caroline			MD.		
10. CITY OR TOWN OF DEATH Ridgely			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) River Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Major			12b. KIND OF BUSINESS OR INDUSTRY Army					
13a. STATE Md.			13b. COUNTY Caroline		13c. CITY OR TOWN Ridgely		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS River Rd.					
14. FATHER'S NAME Casper H. Eicks						15. MOTHER'S MAIDEN NAME Henrietta Menke								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW 11			17. INFORMANT F.B. Stoddert			ADDRESS Annapolis, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3132 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Chronic Alcoholism (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Charles H. Stonesifer M.D.												TITLE (SPECIFY) ASS'T. MEDICAL EXAMINER		
EXAMINER'S NAME Charles H. Stonesifer M.D. (TYPE OR PRINT)												DATE SIGNED July 4 1976		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-7-76			23c. NAME OF CEMETERY OR CREMATORIUM Kensico Cemetery			23d. LOCATION CITY OR TOWN Valhalla Westchester N.Y.			COUNTY STATE		
24. FUNERAL DIRECTOR NAME John S. Bowes			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUL 12 1976			25b. REGISTRAR'S SIGNATURE Patsy McCready					
30M 7/73														
DHMH - 17 (VR A15 ME (5))														

10-17-38

W.H. and D.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 76-17811	
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Nola Belle Ricketts								July 5, 1976				6P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		Negro		Nov. 2, 1891				84 YRS.				IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8				9. BALTIMORE CITY OR COUNTY OF DEATH					
Harmony, Md.		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				Caroline					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Williamsburg		St. Mary's Nursing Home				Domestic				Homes			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Caroline		Federalsburg				117 Idlewild Road					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Henry Stanford		Martha Beulah											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		ADDRESS					
No		215-20-1082A				Martha Stanley, 117 Idlewild Road, Md. 21632		Federalsburg,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Chronic Congestive Cardiac Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4/22		DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive arteriosclerotic CV Disease yrs										1mos	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8/28/76, 19, to 7/5/76, 19, that (I) (we) last saw the deceased alive on 6/24/76, 19, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.													
22b. SIGNATURE <i>B. Plummer</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED 7/8/76													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Harold B. Plummer, M.D.		Maple Avenue, Preston, Maryland 21655											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN		CITY OR TOWN COUNTY STATE			
Burial		July 10, 1976		Federal Hill Cem.				Federalsburg		Caroline, Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Frampton-Hawkins Funeral Home,		216 N. Main St.				JUL 12 1976		<i>Hector McCreedy</i>					

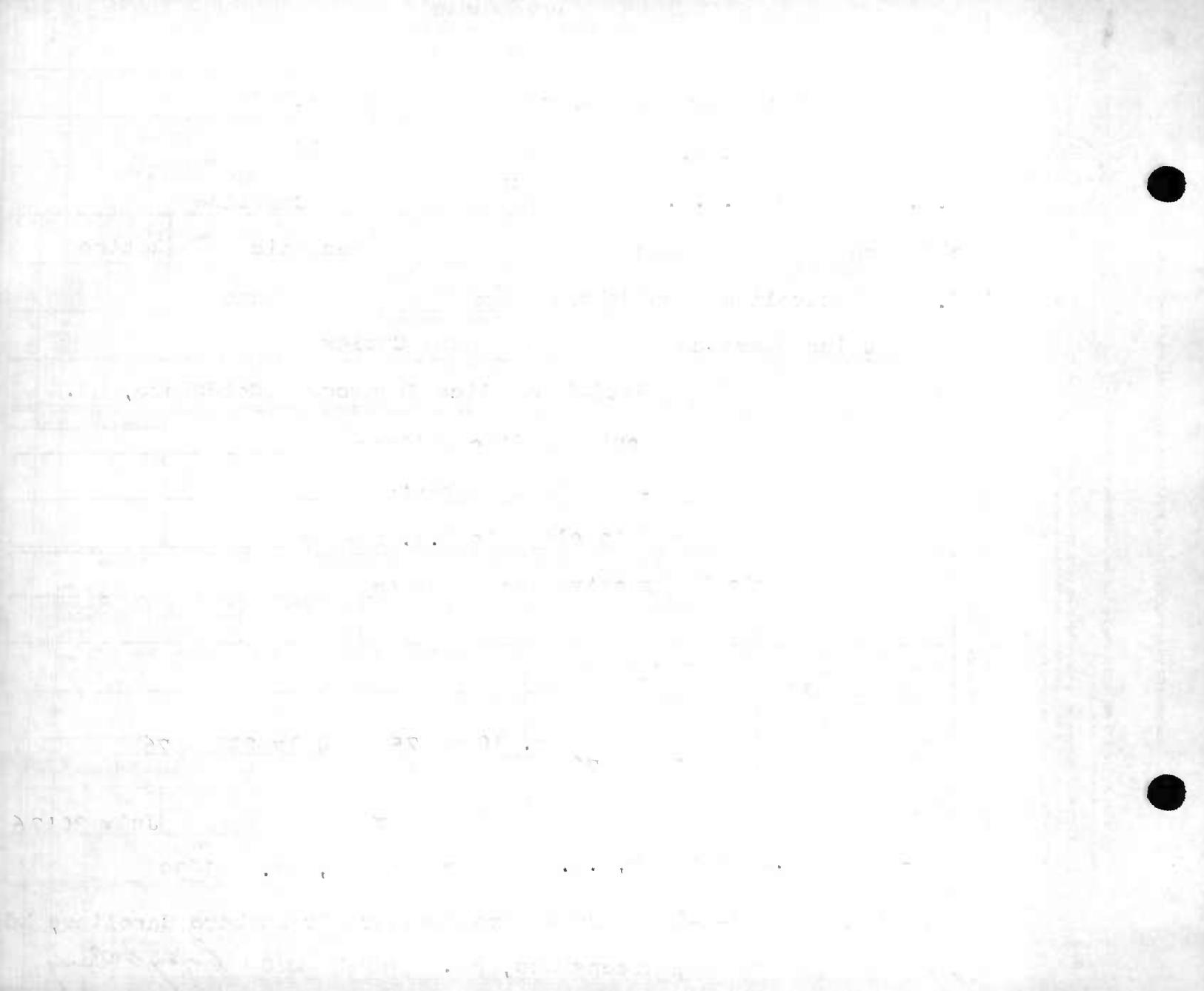
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. <i>76-17812</i>			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			William Edward Shamrock						7-29-76						
3. SEX Male			4 RACE Cau.			5. DATE OF BIRTH MONTH 2 -DAY 8 -YEAR 04			6. AGE (IN YEARS LAST BIRTHDAY) 72			IF UNDER 1 YEAR MONTHS YRS. DAYS		IF UNDER 24 HRS. HOURS M.D. MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Caroline						
10. CITY OR TOWN OF DEATH Goldsboro			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. STATE Md.			13b. COUNTY Caroline			13c. CITY OR TOWN Goldsboro			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS None			
14. FATHER'S NAME FIRST Julius			MIDDLE Shamrock			LAST			15. MOTHER'S MAIDEN NAME FIRST Anna			MIDDLE Cutler LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 055-26-8260			17. INFORMANT Alice Shamrock			ADDRESS Goldsboro, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF Coronary Thrombosis												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic C.V. Disease															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Chronic Obstructive Lung Disease															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from Sept. 10 , 19 75 , to July 29 , 19 76 , that (I) (we) last saw the deceased alive on July 29 , 19 76 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED July 30 '76			
23d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles H. Stonesifer, M.D.			22e. ADDRESS Greensboro, Md. 21639			23f. DEGREE <i>Surgeon & Hospitalist</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-1-76			23c. NAME OF CEMETERY OR CREMATORIAL Greensboro Cemetery			23d. LOCATION CITY OR TOWN Greensboro			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>John Bowles</i>			ADDRESS Greensboro, Md.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>Hickey McCready</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 11, G497 7/23/76 bal
FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

76-17813

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
CLINTON EARL STEVENS, JR.				JULY 7, 1976					
3. SEX	M	RACE	W	5. DATE OF BIRTH					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
7c. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH					
DENTON		Hobbs Road		CAROLINE					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS				
13a. STATE Md		13b. COUNTY CAROLINE		13c. CITY OR TOWN DENTON					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME	12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY
CLINTON E. STEVENS SR.				SUSAN	CABINET MAKER BLD.				M.D.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	ADDRESS				
NO				MRS CLINTON E. STEVENS JR. DENTON					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis (c) Arteriosclerotic Cardiovascular Dis.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute & Chronic Obstructive Lung Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1974, to July 7, 1976, that (I) (we) last saw the deceased alive on July 7, 1976, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED July 8 '76
22b. SIGNATURE Charles H. Stonesifer		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles H. Stonesifer, M.D.		22e. ADDRESS P.O. Box 247 Greensboro, Md. 21639							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE JULY 9, 1976		23c. NAME OF CEMETERY OR CREMATORIAL UNITY WASHINGTON		23d. LOCATION CITY OR TOWN HARRODG. DR.		COUNTY M.D.	
24. FUNERAL DIRECTOR NAME Moore Funeral Home		ADDRESS DENTON, MD.		25a. DATE REC'D. BY REGISTRAR JUL 13 1976				25b. REGISTRAR'S SIGNATURE Anthony McCready	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

76-17814

FOR STAN
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. In case of delay, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

LILLIE MAY WILLIS													
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	2b. HOUR	
LILLIE MAY WILLIS						7	27	1976	19	305A	M		
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR		IF UNDER 24 HRS.				2d. HOUR	
F		W	AUG 21, 1957		18	MONTHS	DAYS	HOURS	MIN.			2d. HOUR	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. COUNTY OF DEATH	
MD		USA		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		CAROLINE	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRy				
FEDERALSBURG			RURAL FEDERALSBURG			FEDERALSBURG			FEDERALSBURG			ELECTRONICS	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER				
MD			CAROLINE			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
WILLIAM J. WILLIS						NORMA					LAYTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO						MRS. ALBERT R. WHITE			FEDERALSBURG				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Ruptured abdominal Viscus & multiple</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) <u>Injuries Fracture rt Femur Radisus. Ulna</u> seconds													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			505 7/27/76			Car hit a tree crushing occupant above							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County		State	
WHILE AT WORK <input type="checkbox"/>		ROUTE 577 FEDERALSBURG Maryland											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Harold B. Plummer</u>													
EXAMINER'S NAME (Type) Harold B. Plummer M.D.													
22b. DATE SIGNED			7/27/76										
23. NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify) DENTON													
22c. LOCATION (City or Town)			DENTON			23d. LOCATION (City or Town)			DENTON				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
MOORE FUNERAL HOME			DENTON			DATE JUL 29 1976			Plummer, already				



REF ID: A6510100000000000000000000000000